

Department of Insurance  
Division of Health Insurance Policy and Managed Care

**ADDITIONAL HEALTH INFORMATION REQUEST FORM**

«Current Date»

«Company\_Name»

Attn: «Contact\_Person»

«Address1» «Address2»

«City» «State» «Zip»

RE: Co. Ltr Date: «Co\_Letter\_Date» Fax No: «Fax\_No»  
Form No: «Form\_No»  
Co. Filing No.  
Date Received: «Date\_Received» KY DOI Filing No:  
«KYDOI\_File»

The information referenced above cannot be accepted as submitted because of the following reason(s) and/or omissions:

- ( ) HIPMC-F1 Face Sheet & Verification form was not submitted. **(Please submit in duplicate)**
- ( ) Incorrect F-1 was submitted
- ( ) Filing fee of **\$5.00** for each single subject of coverage of insurance filed or the domiciliary state fee, whichever is greater.
- ( ) Health rate revision - **\$100.00** (Reference 806 KAR 4:010)
- ( ) \_\_\_\_\_ Additional filing fee is required.
- ( ) Certification Form by President (Form HIPMC-F2)
- ( ) Actuarial Certification (Form HIPMC-R4)
- ( ) Actuarial Demonstration ( ) Rates ( ) Signature on
- ( ) Flesch score (Reference 806 KAR 14:121)
- ( ) Filing fee of \$25.00 for provider agreement ( ) or subcontract agreement ( ) pursuant to 806 KAR 17:300, Section 2(3) (b)1.
- ( ) Filing fee of \$50.00 for risk sharing agreement pursuant to 806 KAR 17:300, Section 2(3)(b)2.
- ( ) HIPMC-R36 Rate Filing Information Form
- ( ) Other

If the requested item(s) are not received within **thirty (30)** days from the date of this letter, the forms involved **will not** be retained for future reference.

For identification purposes, please submit a copy of this letter with the requested item(s) to the Kentucky Department of Insurance, Division of Health Insurance Policy and Managed Care, Attn: \_\_\_\_\_ P.O. Box 517, Frankfort, KY 40602-0517, or 215 West Main Street, Frankfort, KY 40601.